CLAIM FORM AND INSTRUCTIONS

If you have any questions while completing your claim or need assistance, please call Keeler & Associates (GoToSMBO.com) at 877-282-0808.
7:00 A.M. to 5:00 P.M. Central Standard Time

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

INSTRUCTIONS FOR FILING YOUR GROUP ACCIDENT CLAIM

- Please check the box or boxes that best describes your current claim:

☐ Dismemberment
☐ Dislocation/Fracture
☐ Initial Hospitalization Confinement
☐ Medical Expenses
☐ Ambulance Services:
  ☐ Ground Ambulance
  ☐ Air Ambulance
☐ Accidental Death*
☐ Common Carrier Accidental Death*

* **Should someone covered under this policy suffer an accidental death, please call 1-904-992-2556 so that we may provide special assistance**.

- Providing the documentation requested below will ensure that your claim can be processed for benefit. The following is the documentation that is **required** for **ACCIDENT CLAIM:**
  ☐ A copy of the itemized billing statement and a radiology report if filing for the fracture benefit.
- Include your policy number(s). To obtain your policy number call **1-877-282-0808**. Please be assured that your claim will receive our prompt attention.
- You may **fax** your claim to us at **1-402-296-3954**. Please be assured that your claim will receive our prompt attention.
- You may mail your claim to: **GoToSMBO.com c/o Keeler & Associates**
  211 S. 23rd Street
  Plattsmouth, NE 68048
- Additional claim forms are available on our website at www.allstateatwork.com.
- If you are filing a claim within the first 12 months your policy is in force, additional information may be required.

POLICYHOLDER / CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____

   Policy Number(s): 1)_____ 2)_____

   Social Security Number: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

2. Home Number: (___) _____ **E-mail:** _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ ☐ Male ☐ Female
5. This person is your: _____ (ex: self, wife, son, etc.) Is he/she a full-time student? ☐ Yes ☐ No
   If yes, please submit proof of student status.

GROUP ACCIDENT POLICY CLAIMS

DATE OF ACCIDENT: ___/___/___ **Time of accident:** _____ ☐ **a.m.** ☐ **p.m.**

Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

_____

_____

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Patient's Name: _____ Policy Number: _____

1. Diagnosis: _____

2. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR

3. When did patient first consult you for this condition? Date ____/____/____ MO/DAY/YR

4. Has patient ever had same or similar condition? (If "yes," state when and describe.) ☐ Yes ☐ No _____

_____

5. Describe any other diseases or infirmity affecting present condition. _____

6. Nature of surgical procedure, if any (describe fully). _____

_____

7. If patient is hospitalized, give name and address of hospital.

   Hospital: _____ City: _____ State: _____

8. Date admitted: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

9. Referring Physician: _____ Phone: (____) _____

   Mailing Address: _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

ASSIGNMENT OF BENEFITS (n/a in New Hampshire)

Please complete this section ONLY if you wish for Allstate to send your benefit to your medical provider instead of to you.

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send benefits available to the name and address shown below:

_____ Name

_____ Address

_____ Provider's Tax Identification Number

_____ City State Zip

_____ Relationship

_____ Signature of Policy Owner

_____ Date

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Date:_____ ☐ **CHECK HERE IF ADDRESS IS NEW**

Claimant

Mailing Address:_____City:_____State:_____ Zip: _____Phone No:. (_____)_____

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DISTRICT OF COLUMBIA: FRAUD NOTICE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NOTICE IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Allstate Workplace Division

CLAIMS ADMINISTRATION

DIRECT DEPOSIT AUTHORIZATION FORM

Authority is hereby given to American Heritage Life Insurance Company (AHL) to credit the account number shown below for claims payment for all of your AHL policies (unless benefits are assigned). AHL will make any adjustments, including the initiation of any credit or debit entries on the account, for the limited purpose of claims payment due to the accountholder or due to AHL. Once the deposit transaction occurs, AHL has five days to withdraw only the amount deposited if an error has occurred.

TRANSACTION TYPE: ☑ New Setup ☐ Cancellation ☐ Change Financial Institution ☐ Change Account Number

POLICY/CERTIFICATEHOLDER INFORMATION:

Policy/Certificateholder Name: _____ Home Phone: _____

Policy/Certificate Number(s): _____/_____

(Signing this authorization will allow AHL to deposit claims payments for all eligible policies)

Social Security Number: _____

FINANCIAL INSTITUTION:

Financial Institution Name: _____

Address: _____

Routing Transit Number _____ Account Number_____

Tape a Voided Check for Checking Account Here

This authority is to remain in full force and effect until AHL has received written notification revoking the authority. Your policy/certificateholder information and your financial institution information above must be complete and accurate and must be that of the policy/certificateholder on file. To ensure accuracy, a voided check must be attached. Please notify AHL immediately if your financial institution or account information has changed by sending written notification to the address indicated below. Should you have any questions, please contact us at 1-800-348-4489.

Authorization Signature: _____ Date: _____

Print Name: _____

Deliver the completed and signed authorization form with voided check to:

Fax to: 1-402-296-3954 OR **Mail to:** Allstate Workplace Division
Attention: Claims ACH Department
1776 American Heritage Life Drive,
Jacksonville, FL 32224-6687